EDUCATION DEVELOPMENT CENTER INCORPORATED

Moderator: Carol Oliver
June 30, 2005
1:00 p.m. CT

Operator: Good day, everyone. And welcome to today's Northeast CAPT Co-Occurring Substance Use and Mental Health Disorders and the Role of Prevention conference call. Today's conference will be open and interactive for the duration. We do ask that you use a mute button when not speaking to cut down on background noise.

Also, if you need to step away from today's call, please do not place your line on hold, as doing so may feed music into the entire conference. As a reminder, today's call is being recorded. Before we get started, we would like to conduct a brief roll call to ensure all lines can be heard clearly. When I call out your name, please respond with the company you're with, and anyone who may be sitting with you today. Let's start with Susan Cullen.

Susan Cullen: I'm here, with Pat Phillips and Mark Grant.

Operator: Angel Velez?

Angel Velez: Angel Velez and Joan Alvarez-Rashid.

Operator: As a reminder, please also state what company or clinic you are with.

Female: OASAS, New York State.

Operator: Beverly Pierce? Beverly Pierce?

Beverly Pierce: Beverly Pierce, with Student Assistant Services.

Operator: Thank you. Freddie Landry?

Freddie Landry: Freddie Landry, with Jefferson Parish Louisiana District Attorney Paul Connick's Office.

Operator: Thank you. Nina Licht?

Nina Licht: Here with Delaware Division of Social Services.

Operator: Candace Hodgkins?

Candace Hodgkins: Candace Hodgkins here, with Gateway Community Services in Jacksonville, Florida; and Frida Coley.

Operator: Thank you. Jose Morales?

Jose Morales: Jose Morales, the Massachusetts State Department of Public Health.

Operator: Linda Williams?

Linda Williams: I'm here, the Maine Office of Substance Abuse.

Operator: Yvonne Bunch? Yvonne Bunch? Moving on, we'll hear from John Shipherd.

John Shipherd: John Shipherd, OASAS.

Operator: Brenda Amodei?

Brenda Amodei: I'm here, from the Rhode Island Department of MHRH Behavioral Healthcare Services, with Marco Andrade.

Operator: Thank you. Susan Delattre?

Susan Delattre: Susan Delattre here, with Gifford Medical Center, and Barbara Gassner and Kim Hannon-Broft.

Operator: Thank you. Adrienne Buckle?

Adrienne Buckle: Kern County Mental Health, in California Behavioral Health Services.

Operator: Great. And Peter Phillips?

Peter Phillips: Peter Phillips, Catholic Charities Maine; St. Michael's Center, Bangor, Maine.

Operator: Great. Carol, could you hear all the lines clearly?

Carol Oliver: Yes.

Operator: Please go ahead.

Carol Oliver: Great. Well, thanks, everybody. And welcome to our audio conference call on Co-Occurring Substance Use and Mental Health and the Role of Prevention. And from the Northeast CAPT, we want to welcome you to the call.

I first want to give some brief background of sort of how we came at the Northeast CAPT to doing this particular topic. Every year, the Northeast CAPT, in providing technical assistance and training services to states in the Northeast – through our site visits, we found that this was a particular topic that was arising when we were talking to state systems. There were a lot of questions about mental health and substance abuse treatment, integrating their services; and what was the role of prevention in this.

We have put together a dynamic panel that will provide you with multiple, different aspects on this particular topic. To begin with, we're going to hear from Deb McLean-Leow, who is going to provide us with an overview to frame the topic of cooccurring and the role of prevention.

We're also going to hear from Jon Dunbar-Cooper, who is going to provide a federal perspective on the topic. We're going to hear from Dianne Harnad, from the State of Connecticut, who will provide you with some information and perspective on the State system of Connecticut and what Connecticut has done in reference to looking at prevention in cooccurring disorders.

And we're going to hear from Jim Wuelfing, who will provide you with other experiences working with states, and their experiences integrating, as well as with local professionals. So I welcome you all to the call. And I want to remind everybody, just in reference to – if you have any problems hearing, or if you find that you have a fire engine going by, or any other kind of noisy thing, feel free to use the mute button. And that will help significantly with the call.

I want to begin by introducing Deb McLean-Leow. Deb is the Associate Director for CSAP's Northeast CAPT. She has worked with state and community providers and leaders for eight

years to make evidence-based subsidies prevention programs and practices available and accessible to local communities. And she has a wealth of experience and knowledge. So, Deb?

Deb McLean-Leow: Hi. Welcome, everybody. I first want to apologize. I just ran down the hall, eight months pregnant, to switch phones before my other phone died. So I'm quickly trying to catch my breath here. But I'd like to welcome all of you to today's call.

And for those of you who were involved in trying to get on previous calls, and know about our dilemmas with those calls, I want to thank you for your patience and your perseverance in coming back to these calls. So we're all keeping our fingers crossed today, hoping that no fire alarms go off.

So with that said, what I'd like to do is three things. First I want to give you some background information about our interest at the Northeast CAPT in this topic. I also then want to provide some common language for us to use to guide our discussion. And then I want to introduce the concept of a window of opportunity to do prevention, in the context of co-occurring disorders.

So, where I'm going to begin is with giving you some background information about our interest at the Northeast CAPT, in looking at the role of prevention in co-occurring substance use and mental health disorders. And I guess what I'd like to do is share some of my thoughts about what seems to account for this growing interest in this particular topic nationally and in our region.

So first, nationally – the bottom line is – and I'm actually interested in hearing your thoughts as well, about why you believe or feel that the topic is getting so much attention; in particular, you know, the growing interest in the role of prevention. So first, you know, my thought is that there's a growing body of research that examines the role of prevention and early intervention in co-occurring substance use mental health disorders.

And much of this research focuses on risk and protective factors. And I think in part, as a result of this body of research, there is growing consensus among researchers and practitioners that some co-occurring disorders can be prevented. So I think one of the primary reasons for the growing conversation that we're hearing is the science of prevention in this area is beginning to emerge.

Secondly, there's a focus at the federal level on this topic. And much of the focus, beginning with the SAMHSA report to Congress on co-occurring disorders – and you're probably going to hear more about this from Jon, who is our SAMHSA rep on the call. And that report then became a blueprint for subsequent SAMHSA initiatives, which Jon will talk about.

And then, I think to some extent – this goes back a couple years – but the events of September 11th also brought greater public attention to mental health and substance abuse in the aftermath of trauma that so many people experienced. And as a result of September 11th, there was a significant amount of funding going towards recovery and resiliency, focused on mental health and well being, but also on, you know, interventions to treat any sort of mental health conditions that were sort of brought on by September 11.

Now, at the Northeast CAPT, our work in this area really began after September 11. And in the aftermath of September 11, we were getting requests from states and communities to provide information and guidance on both mental health and substance use, and in particular the overlap between the two.

Some of you may recall that there were – there were articles in *The New York Times* after 9/11, you know, talking about the increased rates of substance use among the individuals who were involved in the recovery efforts in New York City, as well as increasing, you know, mental health conditions and disorders.

And so state agencies and substance abuse authorities in New York, New Jersey and Connecticut, at least in our region, and their local providers, were being asked to do work related to recovery and resiliency. And in New York, for example, OASAS – those of you who are from OASAS on the phone will know this – that OASAS, as part of an interagency team, was involved in spearheading a campaign on recovery and resiliency.

And local substance abuse funding was being earmarked specifically for communities directly impacted by 9/11. The CAPT was being asked to assist in some of those efforts in response to these larger trends that have happened federally and nationally, and the requests that were coming in, we at the Northeast CAPT implemented a number of initiatives.

So for starters, in the spring of 2002, we convened a very small cross-center workgroup at our parent organization, which is Education Development Center in Massachusetts, consisting of mental health and substance abuse practitioners: mostly social workers, who were working on mental health projects and the CAPT. And I was part of that team. And this team was convened to sort of begin to develop a body of work on this topic.

And then soon after that, we conducted a focus group, with local and state providers on co-occurring conditions at the New England School of Prevention Studies. And I know that some of you on the phone were part of that focus group. And the purpose of that focus group at the time was to help us better understand some of the challenges that practitioners were facing as they tried to implement evidence-based programs and other strategies that were geared at both mental health and substance use and abuse.

And so some of the things that we heard through that focus group included – folks felt that there wasn't enough synthesized research available that could be used to help both parents and fellow professionals understand what role prevention plays in this whole mental health substance use-substance abuse process.

Folks asked for a matrix mapping out different substance abuse prevention and mental health programs and practices, accompanied by research, talking about how these practices could be integrated. They also wanted more information on culturally appropriate practices. They wanted stronger recognition of programs that attempt to address both substance abuse and mental health problems in youth.

And lastly, I would mention that folks felt that they needed a common language to have conversations across mental health and substance abuse. So those are some of the things that we heard back then. And since then, in response to this feedback that we heard from the field, we did a couple of things.

We developed some conference papers. One, for example, was on promoting – it was entitled "Promoting Access to Mental Health and Substance Abuse Prevention Services in a Culturally Diverse Society," which was presented at the second world conference on promotion of mental health and the prevention of behavioral disorders, in London, of all places.

And following that, we then developed an internal working paper, like a white paper, on co-occurring disorders, in part to help us understand what these issues were, and where the research was at. And related to that white paper, we also developed a comprehensive bibliography on the topic. And this bibliography I know is available currently on our Web site, in the same section of our Web site that information about this audio conference is located.

We also hosted some expert discussions on co-occurring disorders at the National Prevention Network conference. And importantly, last year, in April of 2004, we developed a collaborative partnership between the National CAPT System and the new SAMHSA's National Co-Occurring Center for Excellence, which has been incredibly beneficial to myself and colleagues at other CAPTs, as we try to figure out what work we can do in this area.

And the other thing that I would say is that most recently, in October, the CAPT along with our colleagues from SAMHSA did a presentation on prevention strategies: what works, at National Policy Academy on Co-Occurring Disorders in Washington, D.C. And in some ways, I mean, a lot of what we're going to be talking about today comes out of our experience at that Policy Academy.

And the last thing, then, that I would mention is we have created and produced a national Webcast on co-occurring disorders. I think it's called "Windows of Opportunity: The Role of Prevention in Addressing Substance Abuse and Mental Health Disorders." And that Webcast is currently being reviewed by SAMHSA. And when it is available, we will send out an announcement to the (field), so that you all can view it on our Web site.

So that is just some background information on what we've done, and why we have become involved in this topic. I guess I'm also curious to know, at some point – or at any point during the discussion – if any of you would like to share your thoughts about why you think there's this growing interest nationally, not only on co-occurring disorders, but also on the role of prevention.

I'd be interested in hearing your thoughts about that. So that's background information that I want to share. The second thing that I want to do is – before we go into any further discussion – is sort of establish a common language and definitions that we'll be using throughout the conversation today.

And when we at the CAPT use the term co-occurring disorders, we're using both a DSM-IV definition of co-occurring disorders as well as a service definition that was – that was recently published in a guide developed by the Co-Occurring Center for Excellence.

Now most of you are probably aware and familiar with the DSM-IV definition, which basically states that an individual with co-occurring disorders has one or more substance-related disorder – you know, alcohol, cocaine, nicotine, et cetera – and one or more mental disorder – depression, anxiety disorder, suicidal ideation, et cetera. There's more to that definition and you can get that information from my slides. I'm not going to read through the whole thing right now.

I think, secondly – and perhaps most pertinent to our conversation today – is the service definition of co-occurring disorder. And what do I mean by that? Well, the bottom line is that a person may require or could benefit from co-occurring services. But they may not meet the DSM definition of co-occurring disorder.

And examples of this would be an individual who, for example, is pre-diagnosed. They may have established this diagnosis in one domain; let's say, in the substance-related disorder domain. And they may have signs and symptoms of an emerging disorder in a mental health domain. But see, they don't quite yet meet that DSM-IV criteria. But they're clearly at high risk. And so, this sort of individual could clearly benefit from co-occurring disorder services.

In addition to that example, the other example that is given here is individuals who are post-diagnosed with co-occurring disorder. You know, they may either have a substance-related or mental disorder – it's resolved for a substantial period of time. But, like individuals with either an addictive disorder or any other disorder, there is need for relapse prevention services that helps them to maintain their post-diagnosis status in a healthy way.

And the final aspect of this service definition is an individual who may have a unitary or one disorder and acute signs or symptoms of another. So for example, if maybe an individual who is diagnosed with substance use disorder and has periodic or induced paranoia or anxiety, or suicidal ideation related to their drug use – or it could be an individual who is mentally ill, seriously mentally ill, and shows up at an emergency room intoxicated.

And their intoxication may be episodic. They may not be diagnosed with an addictive – a substance abuse disorder. But they may just have these episodes of intoxication. So these individuals can benefit from code services. They can be assessed, they can be intervened with, et cetera.

So for these reasons, when – it is recommended by the Co-Occurring Center for Excellence that, when we plan and design programs to target this population, that we use the service definition. Otherwise, we do run the risk of losing folks who could benefit from needed services and who are not yet diagnosed.

And, you know, along the same lines, if you think about it, the individuals who fall under that service definition category – these are the individuals who may benefit the most from preventive or early intervention services. Because they're diagnosed with one condition.

And they're at risk for developing another, or they're showing signs and symptoms, et cetera. So that is just some background information that we tend to draw on when we talk about co-occurring disorders. Carol, how am I doing for time?

Carol Oliver: You have some more time.

Deb McLean-Leow: (OK), good. In the slides that I have on the Web site, I found this really interesting quote from the 1960s. It was actually put out by – it was a quote from JFK. And I found it interesting, because he was talking about prevention back then.

And in part, I think that has to do with some family history in the Kennedy family around mental illness and serious emotional disorders and mental retardation, et cetera. But, you know, the part of the quote that I'm drawn to is where he says, "programs directed at known – prevention will

require both selected specific programs, directed especially at known causes, and those that eliminate or correct conditions associated with mental illness."

So, you know, the idea of prevention, as it relates to mental health, is certainly not a new concept. I mean, JFK was talking about it back in the '60s. Now, fast-forward to about 30 years, three decades, since JFK made that statement. And the IOM – Institute of Medicine – many of you are probably familiar with the IOM (FAN). Well – which is also in my slide. And if you're familiar with the (FAN), you'll know that the (FAN) suggests that prevention and intervention should precede treatment.

It basically shows the placement of prevention at the forefront of any effort to stem the tide of disease, the onset of disease or the progression of diseases in a population. And then finally, as I mentioned earlier, I mean, there is growing consensus and recognition among researchers that we have to look at how to offset those co-occurring disorders that can be prevented.

Now, there's some other language that we can't just throw around when we talk about mental health and substance abuse and prevention. And one of those terms is "mental health promotion." And I think it's important to distinguish between mental health promotion and the prevention of mental disorders.

And usually, you know, many of you are probably familiar with the fact that when the term "mental health promotion" is used, it's often associated with the promotion of social and emotional competence and well being in a general population, before the onset of any sort of disability, even before the indication of any risk.

And then, you know, widely used also is the term "prevention of mental disorders." And in some ways, if you think about it, the prevention of mental disorders has to be much more deliberate

than – and targeted at a selective or indicated population, at increased risk – much more deliberate than a more universal, you know, mental health promotion approach.

And so when we talk about mental – the prevention of mental disorders, I mean, we're basically talking about those interventions that prevent the occurrence of a mental health disorder, and also interventions that would slow down the progression of disease or, in our case – in particular today – prevent comorbidity, or prevent relapse.

There is also – I've included for you a public health definition, which many of you have seen, of mental disorder prevention, that's been widely used, I believe. It came out in 1994. It has been adopted by the World Health Organization. And, you know, it basically focuses on reducing the incidents and prevalence and re-occurrence of mental disorders, the time spent with symptoms, or the risk condition for mental illness.

So by way of throwing out there just some common terms that we tend to use, and wanting to make sure that we're kind of all on the same page about these terms that are often used. I'm going to move now to introduce this concept of a window of opportunity. It's the third thing that I want to do. And in my slides, I've included some data about ...

Carol Oliver: Deb? I'm going to interrupt you for a second.

Deb McLean-Leow: Yes.

Carol Oliver: Just want to make sure that we had on the overview that came with the audio announcement – and we also yesterday sent out an additional e-mail reminder – I just want to make sure that everybody, when you're referring to slides – because I didn't – I apologize I didn't say it at the beginning of the call – that Deb's slides are located on the overview.

And you can also go to our Web site at www.northeastcapt.org/services/technology/audioconferenceindex.html. And you can also find the slides there as well. It's on the overview. And you just scroll down to resources, and you'll see it under Deb McLean's name.

Deb McLean-Leow: And if you got the e-mail this morning, both my slides and the slides for Dianne Harnad ...

Carol Oliver: Are there.

Female: Right.

Carol Oliver: I just wanted to make sure people knew that.

Deb McLean-Leow: If you don't – if you didn't get them, we can always send them to you after the conference call. Thanks, Carol.

Carol Oliver: Sure, sure, not to interrupt.

Deb McLean-Leow: So, you know, there's some conflicting data out there. I mean, some of you are probably familiar with the fact that back in 2002, Ron Kessler's national co-morbidity survey, you know, has the national prevalence of co-occurring disorders as up to 10 million individuals.

Most recently, though, SAMHSA's national household survey has incidence and prevalence rate of four million people with co-occurring disorders. So just want to draw your attention to those two sources of data. There's also some prevalence data that come from treatment programs. And again, much of this is based on Ron Kessler's work.

So, you know, from his work, I think we know that about 25 to 50 percent of clients in mental health programs also have substance use disorder, something that's not news to many of you who work out there in the field. This is the reality. And up to 50 to 75 percent of clients in drug treatment also have mental health disorders.

Now to the concept of the window of opportunity. So basically a whole lot of people out there are dealing with both mental health and substance use disorders. And there are young people at risk for developing both conditions as well. The good news is that research suggests there is a window of opportunity, during which our interventions, preventive interventions, could delay onset, reduce risk, and essentially prevent the development of these coexisting conditions.

And again, going back to the work of Ron Kessler, he found that basically, if you have a mental health problem, you are three times more likely to also have a substance use problem. And if you have a substance use problem, you are four times more likely to experience a mental health problem. And Kessler also found that mental health problems usually present first in about 80 percent of the cases.

And the median – and I think here's the prevention piece. Here's where the prevention message really starts to become a reality. The median age of onset is around 10 to 11 years. And substance use problems follow – so the median (age) of onset for mental health problems is about 10 to 11. And then the substance use problem tends to follow five to 10 years later.

So, you know, there is that window of opportunity, where – if we could intervene when there is – there is the known cases of mental health problems – I mean, be it anxiety or depression or suicidal ideation, and before the onset of substance use disorder – we could actually prevent co-occurring disorders. So it's not rocket science. But, you know, there is – like I said, there's growing consensus. But there's still a lot of controversy around this whole concept.

So part of why we wanted to have this conference call today is to not only share information with you, but also get your sense of what you're seeing in the field, and whether or not your experience out there rings true with some of what, you know, the research is suggesting.

So what I've attempted to do is three things: Basically make some statements about why there's this interest, this growing interest, in co-occurring disorders, and how this relates to the work that we have done at the Northeast CAPT. I've attempted to sort of establish a common language in terms of definitions for our conversation.

Don't want to make any assumptions. So it's always important to establish that common language there – and then third, to introduce this idea that there is a window of opportunity based on incidence and prevalence data, that prevention of coexisting or co-occurring disorders is possible. So thank you for listening to me, as I went on and on. Carol, back to you.

Carol Oliver: That's great. Thanks, Deb, very much. To continue the conversation, also in reference to the federal level, and how SAMHSA views this, I want to introduce Jon Dunbar-Cooper, who has a wealth of experience working on the federal level.

And he currently serves as a public health advisor for CSAP in the Division of State and Community Assistance. And he administers and monitors 20 percent set-aside of the Substance Abuse Prevention Block Grant, State Incentive Grants and Strategic Prevention Framework State Incentive Grants. And welcome, Jon.

Jon Dunbar-Cooper: Hello, everybody.

Carol Oliver: Hello.

Male: Hi.

Jon Dunbar-Cooper: I will attempt to give the federal perspective on this. And I guess we'll start with the report to Congress that was done in 2000, where the federal government felt that it was very important to look into co-occurring disorders to improve access to and quality of care.

The report acknowledges that effective treatment includes time-sensitive training, and that we need to integrate treatment and mental health systems to address the needs of persons with co-occurring disorders. The Substance and Mental Health Services Administration (SAMHSA) was mandated to do this because SAMHSA is the lead federal agency for substance abuse and mental health treatment. Shortly thereafter, Mr. Charles Currie became SAMHSA's administrator and instituted the SAMHSA Priorities: Programs and Principles Matrix, which has a designated lead for co-occurring disorders.

I served on three co-occurring SAMHSA committees -- Policy Academy for Co-Occurring Disorders, the Co-Occurring Matrix Committee and the Native American Co-Occurring Sub-Workgroup of the Policy Academy Committee. Through grants such as Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services' (CMHS's) Co-Occurring State Incentive Grant (CO-SIG), SAMHSA is asking states to build on existing infrastructures and integrate and improve their substance abuse and mental health systems to provide state-of-the-art treatment to persons with co-occurring disorders and their families. Additionally, through CSAT's Access to Recovery Grant (ATR), states have greater flexibility with voucher programs to increase access to services to better meet the needs of persons needing substance abuse treatment. Persons receiving treatment have more autonomy in choosing an appropriate provider and can mix and match recovery support and clinical treatment services to meet their individual needs.

At the last Policy Academy II in Washington, D.C. earlier this year, the Northeast Center for the Application of Prevention Technology (NECAPT) presented opportunities for using model programs and other primary/secondary/tertiary prevention strategies to prevent/reduce influences that may allow a person's substance abuse or mental heath illness to progress to a co-morbid stage. After the Policy Academy II, some states expressed interest in knowing more than just windows of opportunity for primary, secondary, or early intervention as currently practiced – they wanted to know windows of opportunities for prevention across the continuum of care (prevention – treatment – maintenance).

The prevention team on the Co-occurring Policy Academy workgroup decided to speak with the Center for Substance Abuse Prevention's (CSAP's) Director, Beverly Watts Davis, about the windows of opportunity for prevention. We know very well that treatment has a 30-day window to treat people, and that when people return to their homes, sometimes there isn't a safety net to catch those folks. Whether it's a high-risk family or whether it's an individual, very often there are no support systems – Alcoholics Anonymous (AA) and the like. Some people with substance use and abuse disorders and/or mental health disorders do not have the time or the will to go to several venues and stand in line to get the treatment services and the mental health services they need. Coalitions can also help by pointing people in the right direction and providing other resources.

CSAP's model programs (they are listed on the SAMHSA URL) support primary prevention services (Institute of Medicine universal, selective, and indicated) which can also be utilized to support relapse prevention in the maintenance phase of the continuum of care by targeting high-risk individuals and their families and families at risk. And CSAP recognizes that the number of people with co-occurring disorders can be decreased if primary health care venues screened for mental health and substance abuse disorders as early as possible (the onset of the disease may take 5 to 15 years to detect) before an individual begins abusing substances and/or self-medicating to mask their mental illness. CSAP does not have the resources or policies in place to

support early screening in primary care settings. However, CSAP's Starting Early, Starting Smart is one program that targets children from birth to age seven, who are susceptible to abuse, disruptive behavior, or who have parents who lack skills to provide adequate care for their children due to substance abuse or mental health issues.

When we spoke to Beverly Watts Davis, I said, "What about the windows of opportunity in primary care settings where we have an opportunity for screening substance use/abuse and mental illness early?" She recognized that primary care setting window of opportunity but stated that CSAP does not have resources for such an initiative. In the past, CSAP had a managed care training program to train primary care physicians and nurses to screen for substance use and abuse. That program ended about two years ago.

During a meeting recently, at the federal level, we discovered that the Center for Mental Health Services (CMHS) was also looking into training primary care physicians to address mental health disorders at an early stage, so that if it's discovered at age five, seven, eight, nine, ten, the person can receive the appropriate medications before he/she begins either self-medicating with alcohol and other drugs and/or abusing prescribed psychotropic medications. Then you have a co-occurring problem on your hands, where psychotropic drugs are being abused, and where alcohol is being abused, along with other substances. So wouldn't you want to put your money where we are screening early enough to prevent people from self-medicating so we can refer them to appropriate treatment services? If they self-medicate with substances, they are at greater risk for developing a co-occurring disorder.

When people come out of treatment, where are the windows of opportunity for preventing relapse? What can prevention do? Well, we have prevention programs that offer coping, conflict management, and self-esteem building skills, etc. Also, of course, we have programs for high-risk youth and school children – at that point, we can help prevent co-occurring disorders for those

youth who have undiagnosed mental illness because they were reached early enough to prevent them from using substances. So that's another opportunity for prevention.

People coming out of treatment for mental health and substance abuse are also at risk. So for instance, if you have a youth coming out of the juvenile justice system, returning to a volatile home environment with a disruptive parent or sibling, the youth's recovery is greatly jeapordized – that's another opportunity for using appropriate prevention programs to prevent relapse. Another window of opportunity is treatment crisis centers. We need to ask kids about their home situation and their relationships with their parents – often, we only diagnose the individual. We need to look at the risk and protective factors of the entire family in that situation and provide appropriate programs and skills or referrals for them.

So at the Policy Academy in Philadelphia next September, we intend to discuss early screening in primary health care settings for mental health and substance abuse disorders and appropriate prevention/intervention strategies. You can catch problems early and reduce the number of persons needing treatment for co-occurring disorders.

So that's where the federal government is. And it started with the Report to Congress in 2000. This is a new era for us. It's making mental health treatment and prevention work together. We hope that in the future there will be comprehensive grants and programs that truly address all aspects of co-occurring disorders.

We recognize that there are people out there who are trained to do substance abuse counseling and trained to do mental health counseling – one discipline prescribes medications and the other does not. We need to cross-train counselors to preclude clients with co-occurring disorders from receiving treatment from different venues and providers from different disciplines.

So those are the kinds of issues we are addressing. SAMHSA, NIH, NIDA, etc. co-sponsored the Complexities of Co-Occurring Disorders conference in June 2004 – co-occurring disorders has drawn a lot of attention at the federal level. So with that, I will end my discussion about the federal perspective.

Female: Jon, before we turn it back over to Carol, can you just say a little bit more about, you know, what states are typically invited to the Policy Academy, and when the next one is going to be?

Jon Dunbar-Cooper: The next one is on the September 13th, 14th, and 15th in Philadelphia. I do not have the list of the states.

Female: Jon? Hello?

Jon Dunbar-Cooper: John, do you have a list of the states who will be at the next Academy?

Male: No, I don't.

Jon Dunbar-Cooper: I know, and we were just talking about them a few days ago. So I don't – I don't have the list. I know that Arkansas has been invited; that's one of my states. I'm hoping that they will accept the invitation. Right now we have five confirmed, and we're trying to get two more.

N.B. – States confirmed to date for the September Policy Academy are: MT, MD, RI, KS, IN, DE, AR, PA.

And the Policy Academy basically is trying to get states to look at their service delivery systems for mental health and for substance abuse, and to integrate those systems there so that the individual being treated does not have to go to two separate facilities. That is a comprehensive approach for addressing co-occurring disease.

SAMHSA is convening policy academies for states to develop action plans to integrate their systems. States also have the Center for Co-Occurring Excellence (COCE) as a technical assistance tool, and well as other SAMHSA resources. We are encouraging states to do that. At the federal level, we will probably look at how future grants (treatment, mental health, and prevention) can be tailored to better address the needs of persons with co-occurring disorders. We are also looking at transforming mental illness by removing the stigma of the disease and empowering the individual to take control of his treatment and recovery. As I mentioned earlier, we already have the ATR and Co-SIG grants out there to enable states to improve access and quality of the services they provide.

Carol Oliver: That's great.

Jon Dunbar-Cooper: Thank you.

Carol Oliver: Thank you, Jon, very much. That was a very helpful perspective. In rounding out the conversation, we also wanted, in addition to proving you with federal perspective, we wanted to give you an understanding of what a state had done in thinking through the relationship between mental health, substance abuse and prevention.

And Dianne Harnad, from the State of Connecticut, was very generous in offering to come in and be one of our speakers. And Dianne serves as the Director of Prevention Services at the Connecticut Department of Mental Health and Addiction Services. She has over 20 years experience in the fields of public health, substance abuse and mental health. And she is also the Project Director for SAMHSA's newly funded strategic prevention framework. So welcome, Dianne.

Dianne Harnad: Thank you. And hello to everyone.

Female: Hi.

Dianne Harnad: Up to this point, I've found what both Deb and Jon had said very fascinating. As part of my presentation, I'm going to use the phrase "window of opportunity" to tell you about how we got started in Connecticut to expand substance abuse prevention into the area of mental health prevention.

When I talk about windows of opportunity, I'm going to talk about it in two ways: one in looking at the windows to infuse mental health promotion and prevention into our existing state framework; and secondly, in applying mental health promotion interventions in our work with individuals and communities.

I'm not sure if people have the presentation that was on the Web. But basically, my approach has been to try to align the work that we do in Connecticut with SAMHSA's framework.

In Connecticut, the single-state agency for substance abuse and mental health is under one department. So in that respect, we're very fortunate. When I took this position in '98, my Commissioner said to me, you need to grow the mental health side of the department in terms of prevention and health promotion.

We have a very good infrastructure and system of service in our state around substance abuse prevention. Thus, our Commissioner wanted me to look at lessons learned in the substance abuse field, and to try to apply them to mental health. We know that many of the risk factors and the social problems that exist, not only in Connecticut but in other states, have similar risk and protective factors or environmental issues.

One of the first things I needed to do within my own department was to talk to the executive team about the different paradigms that exist within the substance abuse prevention field, and also the

mental health field. In Connecticut, at the executive level, we have folks with knowledge/skills in both fields, some who know little about substance abuse prevention practices.

Additionally we have a Commissioner who's very supportive and well voiced in substance abuse and mental health.

So, the first thing I needed to do was to look at the two paradigms. If you have the PowerPoint, and go to the third page, you will note how I depict the differences in mental health and substance abuse prevention. As you will note, mental health promotion is embedded at all points of the continuum of care.

I really don't like to use the word mental health "prevention" a lot, because people who have been in the field for a long time have difficulty thinking that mental health problems can be prevented, because there's a genetic basis.

On the substance abuse side, you will note the difference in the prevention of substance abuse which has its foundation in primary prevention. That is, we really focused on preventing problems before they get started. Although, there were some similarities e.g., – I believe mental health and substance abuse share common risk and protective factors.

The challenge in Connecticut, around prevention and mental health promotion, was to have people understand and respect both paradigms, and to try to blend the perspectives to reach common ground.

There were several windows of opportunities in Connecticut. The first one I'd like to talk about are the two policy councils that developed as a result of Governor's Blue Ribbon Commission, starting in probably '95. First we had one Commission for substance abuse, and then we had another on mental health.

Both of these advisory bodies were set by the Governor, and all of the Commissioners from all the state departments sat on them. Their role was to set statewide plans, strategy and recommendations across the continuum of care. I saw that as a window of opportunity for expanding prevention in the mental health arena and as a window of opportunity for infusing evidence and science-based programming into our state system.

On the substance abuse side – if you have slide number four – we were fortunate to get the SAMHSA State Incentive Grant, which funded 21 evidence-based model programs for substance abuse, it also called for us to develop a statewide advisory council.

A couple years later, we had the Blue Ribbon Commission. And their goal was to set statewide policy around mental health. We did this before the New Freedom Commission came out with their report. We were a couple of years ahead of them.

The goals of the Blue Ribbon Commission for Mental Health was to determine how mental health, child welfare and criminal justice systems could work together more effectively to maximize collaboration across state agencies and academic and private communities in the area of mental health, and also to determine potential applications of new knowledge in the areas of prevention and early identification of mental illness.

I used that as a window of opportunity. At the same time we did these two state plans, and SAMHSA came out with an initiative from the Center for Mental Health Services side around violence prevention. We used that initiative to start building a mental health promotion paradigm. The Center for Mental Health Services grant allowed us to look at promoting mental health and preventing violence and substance abuse in grades K through 12. We used the Olweus Bullying Prevention Program, and also did some adaptations with the Strengthening Families program. We piloted intervention in two communities, and it worked very nicely. The Center for Mental

Health Services grant also required an advisory council. As a result, we developed what is known as the Connecticut Coalition for the Advancement of Prevention. That was a huge window of opportunity. Because we merged the substance abuse advisory council for the state incentive grant into this greater coalition. Our ultimate goal was not to focus on substance abuse or mental health only, but to look at prevention holistically. We added homelessness, teen pregnancy, and violence, and HIV to the coalition. In Connecticut, I've tried to align what we do with SAMHSA's matrix so everyone knows what the matrix, or the place mat, looks like. It's red and blue, and kind of looks like a flag. It has programs and issues on the left side of the chart, and cross-cutting principles. And within there, you see the strategic prevention framework. And you see a lot of other things that I think intersect with prevention.

The next thing I'd like to talk about is the DMHAS Prevention Infrastructure and programs – Page 6. If you have this house in front of you, which I have on my PowerPoint, you will see that within the State of Connecticut, we look at our programs as a foundation for promoting the health of communities in Connecticut. So as part of our foundation, we have community planning and resource coordination across substance abuse and mental health. We have resource links. We have a prevention training collaborative, a multi-cultural leadership institute, the Connecticut Clearinghouse, Governor's Prevention Partnership, and a statewide asset network. All our resource links do capacity-building, training and technical assistance, not only around substance abuse prevention but also around mental health promotion and violence prevention. And they're responsible for also disseminating information and providing support.

Now within the programs and community-based initiatives, we have programs that link violence, substance abuse prevention to mental health. Under that domain, we have many windows of opportunity, the first one being recovery. When SAMHSA started talking about recovery, within Connecticut, our department jumped right on that. We realized we needed to work with our providers and people in recovery to develop a recovery-oriented continuum of care.

In prevention, we were a part of all the steering committees that were charged with development around recovery. As a result, we developed what we thought were some parallels of where we could use prevention to promote recovery, not only for people coming out of treatment, but also for significant others of people who were already in treatment.

I remember a few years back, I went to a conference. And there was a program in Massachusetts, for instance, where it was on mental health promotion. And it talked about a Strengthening Families program where the children of a woman who had bipolar disorder, were trained to recognize the signs and symptoms of their mom when she was not consistently taking her medication. When the children could see her relapsing, they were able to recognize those signs and symptoms and knew how to react. They would either talk to the mother, talk to the father, or make sure they did an intervention so that she could get treatment. So I found that pretty interesting and great windows of opportunity.

A second initiative we launched with the Center for Mental Health Services funding was to work with girls in alternative education who were victims of sexual abuse. We adopted a program out of Vermont named the Sexual Abuse Free Environment for Teens program. We also adopted it to use in a middle school.

We worked with Latino and African-American girls. A window of opportunity – again, I mean, there's windows all over the place. We also recently applied for a suicide prevention grant, for the entire state. We would like to work with those same schools and train others on the “signs of suicide”. Because we believe those girls are at risk of depression and suicide. As you can see, wherever we think there's an opportunity, we try to align things.

Another area where we've linked substance abuse, violence and mental health was as a result of the dollars that our state was given following 9/11. We put together a curriculum for building strong communities in the aftermath of critical incidents. We did a lot of research, and we came

up with a model using the IOM, but also using prevention technology across the lifecycle, which included education, building social competency, promoting natural care-giving, and systems intervention. This is a model training in and of itself and a toolbox for communities.

Let's go to page seven now, and just really quickly talk about some sampling of the prevention initiatives in Connecticut that we've played off of to show where substance abuse, mental health, and violence or trauma can be integrated or connected.

For example, we have mental health and alcohol-drug policy councils, we have a state prevention council, we have recovery initiative, the strategic prevention framework, trauma and disaster preparedness, our statewide coalition, violence and suicide prevention, work force development, best practice programs, regional action councils and resource links. What we did is basically show how these initiatives cut across all of the prevention domains.

We took – if you go to the next page the Mental Health Transformation New Freedom Commission goals, and within DMHAS we looked at the goals related to prevention. Then we also looked at the DMHAS prevention platform, which is our resource links, our state agency partners, workforce development and different initiatives that we have in place. Then we did a matrix depicting what goals we addressed through our current prevention initiatives. The next thing I'd like to share with you is some cross-cutting initiatives that we're doing in terms of prevention operations and their relationship to other units within our own department and other state agencies.

On Page 9, you will note that we have the two policy councils on substance abuse and mental health. We have needs assessment and planning and our state epi workgroup, which is related to the strategic prevention framework. We have operations related to program monitoring and quality assurance. We have prevention data infrastructure which will be coming down the road; workforce development, operating standards and resource development – and then across the

other continuum, where you can see where all the different divisions in our department are working with us in a collaborative fashion to help us to move those operations forward.

Lastly, a couple weeks ago, many of us – many of my colleagues – we were in Florida for an annual meeting of all of the state directors and NPNs. Mr. Cuhrie was there, and Beverly Watts Davis. After hearing Mr. Cuhrie speak about SAMHSA's priorities, what I did is I came back, and I listed those. Then I aligned what we're doing in Connecticut with them, along with the current initiatives we have in place.

In the PowerPoint on page 10, you'll see the different SAMHSA priorities, which, for prevention, is the strategic prevention framework; sustaining the block grant, which cuts across both prevention and treatment; mental health transformation, national outcome measures, state outcome measures; prevention pathways to recovery. Mr. Cuhrie also talked about a National Guard partnership, or military partnership, which I'm very interested in. Because I think this is a really good window of opportunity for all states to respond, especially states that had to respond after 9/11. I really think we could take what we did back then and adapt it. I believe SAMHSA may feel this way, too.

We can adapt our work for military personnel and their families upon deployment, and also homecoming. Because there are going to be a tremendous amount of issues that come into play with families and trauma, and depression, and things like that down the road. Actually, they're already at our door. Another priority of SAMHSA is preventing co-occurring disorders, workforce development, and putting substance abuse prevention and mental health promotion in the public health arena.

So, I listed the things that we're doing in Connecticut that are related to that, which is the strategic prevention framework, epidemiology workgroup, our data infrastructure, our statewide coalition, our underage drinking coalition in Connecticut colleges, suicide prevention, and the military.

Carol Oliver: Dianne – and I don't mean to interrupt you – but I'm just being aware of time.

Dianne Harnad: OK.

Carol Oliver: Do you mind – do you mind if we wait for future challenges, to give a little bit of time at the very end?

Dianne Harnad: Sure.

Carol Oliver: OK. And thank you so much for all that great information about what Connecticut has been doing, and how you've been integrating mental health and substance abuse services. You gave a lot of really very good examples of that, so people really could get a sense of it.

So, what I'd like to do is also – in the remaining time, too – is introduce Jim Wuelfing. Jim is the owner of the New England Center, a company dedicated to quality training and technical assistance. And his many specialties include prevention, community development, cultural competency, curriculum development, strategic planning, peer education, stress management and problem gambling prevention. So welcome, Jim.

Jim Wuelfing: Thanks. And my hello to everyone as well. I'll try to keep my comments fairly brief so we make sure we have some time for comments at the end. But I will tell you that I'm wearing two hats here. The one hat is that I am one of the two lead facilitators of the state teams that come to the co-occurring policy academies. So I've been to 10 states where we facilitate two days of onsite strategic planning before the states come to the policy academy.

And next week I start on the third round. What I want to share is my experience of that effort. Because I think it'll shine some light on some of the windows of opportunities. The other hat is simply that I've been a prevention professional for a zillion years, back to 1977.

Regarding the experience of the policy academies, the state teams are comprised of representatives of the governor's office, the mental health service continuum, the substance abuse service continuum; both from a policy level and from a service delivery level, as well as clients and consumers who are coming together to try and develop strategic plans to better meet the needs of the co-occurring population.

And I was struck, Deb, by your question very early on about why the emphasis on co-occurring, and why prevention. I think part of the reason for the emphasis on co-occurring is that the prevalent data proves beyond doubt that there are high numbers of clients/consumers who have co-occurring disorders but are either being treated for only one, or if they are being treated for both it's not being done so in an integrated fashion. This leads to fairly dismal outcomes.

And I think that folks know that. I think that they are very well-intended, very hardworking. But their outcomes aren't what they need to be. Part of the reason is that we haven't truly found a way to best integrate those two systems. So that's part of the reason for the emphasis on co-occurring.

And why prevention? Well, I think people are finally beginning to understand that prevention is based on science. And preventionists do have a sense, and know exactly what they're doing – and two, that – and here I quote an unknown source – “that no progress has ever been made against any epidemic by treating only casualties”. I think people have a sense of that.

That being said, when I go to these teams, the vast majority of the people involved are taking a medical, reactive model approach. And they do not naturally think preventively. I think it would behoove us all as preventionists to simply understand that it is not a dismissal of prevention, nor is it anything that's ill-intended

These folks just don't naturally have a prevention paradigm. And so if prevention's going to come to the table and open those windows of opportunities, we have to take it upon ourselves to insert ourselves into the process. The other thing is, in terms of co-occurring disorders, the folks that work in those areas – they are in crisis.

I have not been to a state yet that didn't know very well that they are not even meeting a simple majority of the need of people who have the disorders. And so they are scrambling and dancing just as fast as they can. And they know that they're not even meeting a simple majority of their residents of their states who need these services.

They do not truly understand prevention and the significant advances. They sort of have a sense of it, but they don't really understand it. And they sort of have a sense – is my interpretation – that prevention at the table's a good thing.

They don't really know how prevention can help. They really want to stop the bleeding first. When people are in crisis, they tend to go back to that which they know well. And in this case, that would be sort of a reactive medical model.

So my thinking about this window of opportunity is, first of all, that preventionists need to get involved in the state planning process for co-occurring services, whether that's a co-occurring policy academy team, or whatever the case may be. But most times, these teams come to the policy academy with no preventionists on them. And so we need to find ways that we can be part of that conversation as quickly as possible.

When we do so, we need to be able to provide a concise explanation of prevention, how it can help, and how it can make their jobs not only easier but more effective. I mean, I think everybody knows the job isn't going to be easy. But I think that they welcome any opportunity to make it more effective. Again, the outcomes simply are not what they need to be.

Some of the other things that I wanted to talk about have already been talked about, so I'll be brief. Substance abuse prevention is co-occurring prevention. As was said, in eighty percent of the cases, the mental health issue is antecedent.

And so that if we can start prevention – indicated prevention practices among that population, we could limit the number of people that move into co-occurring and similarly have to deal with one disorder instead of two. My other suggestion would be to focus on skills, not necessarily programs. We're talking systems integration here. We're talking about two systems that largely have evolved over the last 30 years quite separately. And as preventionists, I think that we have the skills to help integration. We know about collaboration.

We know about community mobilization. We know about finding common ground and language. We know how to build consensus. And these are all skills that these folks don't necessarily bring to the table. But I think it's going to be very difficult for them to be successful without having folks there that can help do that.

We know how to work with families. We know how to work within community systems. We have been doing these things for years. And I'm not saying that substance abuse treatment hasn't been working with families. I will say that in the last 15 years, with the advent of managed care, a lot of family programs have been weakened.

And so that's another area that we could use our skills. I just think we naturally know how to do some of these tasks that are desperately needed in this arena. And then finally, to talk just a minute or two about risk and protective factors.

Risk and protective factors is one of those examples. It clearly is becoming part of the language of both substance abuse and mental health professionals. But there's no clear understanding of

how you do it, that is, how do you reduce risk factors while increasing protective factors. There's no clear understanding of how you use multiple strategies over multiple domains to reduce risk factors and increase protective factors.

This is one of the ways that even community preventionists – people who are not necessarily working on the state level – can bring some of their skills and their knowledge to the table, and really help move this forward. That's all for now.

Carol Oliver: Hi. Jim?

Jim Wuelfing: Yes?

Carol Oliver: Thanks. Is that the completion of your comments, Jim?

Jim Wuelfing: It is.

Carol Oliver: OK. Sorry. Sorry about that. So I want to thank all our speakers for contributing. I think what we've got and what we were planning to do with this, before we go into questions, was to really give you a vast perspective between sort of an overview of, when we're talking about the language, what are we looking at, to looking at what the federal perspective is, to hearing an example from the state about what does it look like when you're thinking about prevention and mental health and substance abuse, and as well as Jim's experience working in the policy academy, and what prevention has to offer with substance abuse and mental health in its integration.

So I want to open it up to the callers. I know you've had a lot of speakers. And I'm sure at different points of this, you may have had different questions. But I want to really open it up to all of you to see (if) you have any questions for either individual speakers or just in general.

Female: Carol, I have a clarifying question for Jon.

Carol Oliver: Sure.

Female: And in the beginning of your comments, Jon, you mentioned that CSAP isn't really focusing on early intervention, but mostly in relapse prevention. But then you also went on to site examples of early intervention programs that you all are doing. Can you help – can you clarify that for me? Are you – is CSAP looking at both relapse prevention and the – you know, the early attempts to – like Dianne described in Connecticut – you know, look at young people at increased risk, and target them with interventions to prevent the occurrence of suicide or depression ...

Jon Dunbar-Cooper: Sure. What I was talking about was the very early part of the development of the disease. And that is, when an adolescent is not aware, neither are the parents aware that there is a – that there's a mental health problem – and that that adolescent goes maybe five, 10, 15 years before onset of the disease.

But at the same time, they're self-medicating with alcohol and other substances; whereas if we trained primary care physicians and others in the field to screen for early detection of mental illness, then we can have the appropriate medical drug to prescribe for the disease, and not have it progress to where they are using substances on their own.

So that is where I talked to Beverly Watts Davis and said, in my mind, that's the earliest opportunity that prevention has. But of course, ((inaudible)) mandate isn't one that does that kind of prevention, because it involves mental health. But we recognize that the co-occurring disease can be prevented.

The question for us is, at SAMHSA, whose pocket of money will that come out of? If we choose to train primary care physicians, and do a whole curriculum on that, and everything – does it come from prevention, does it come from mental health, does it come from treatment?

So I'm sure that in the years to come, you will see that that role there will probably end up in CSAP with those trainings because we did have such a training before, but it was for substance abuse detection only, not mental health. So the idea was already there.

So when I speak of early interventions or prevention, that is what I'm talking about now. When we talk about existing programs that we have, that can prevent relapse prevention, or in themselves prevent a child from using substances if they have a mental health disorder. Some of our programs can do that while the child is growing and developing, like SES.

It's an early intervention program for very young children, zero to five, at risk for mental health and other illness – just in high-risk families has been extremely successful. And we have Project Success, that's been successful.

Ellen Morehouse in New York has the student residential program that has been very successful. And there are family-strengthening programs, model programs that we have, that also can address high-risk families. It can address youth returning from the prison system or juvenile system into the home.

But most of all, at the last policy academy, prevention was that through strengthening families, we are going to prevent mental illness. Because strong families are healthy families – and that if a child with a mental illness is within one of the families, they stand a better chance of not using a substance than if they are in a dysfunctional family, with all the stresses and other things they have to deal with.

So we're not saying that prevention will start very early. But we are recognizing that because of strong families, those kids that we would like to detect their illness, their mental illness, at five, six, seven, eight – but even at 12, 13, 14, (15), if they – if they are in a family that had a crisis, or in a family that is participating in one of our model programs, then they stand a better chance of not progressing to having a co-occurring disorder. The problem is how many families participate in our programs, for children who have a mental illness – you may not be aware of it.

Female: Thanks, Jon.

Carol Oliver: Thanks, Jon.

Jon Dunbar-Cooper: You're welcome.

Carol Oliver: Are there other questions from the participants?

Operator: I'd like to remind everyone your line is open. You can please ask your question freely.

Angel Velez: I have a question – this is Angel Velez, from OASAS, New York City – New York State.

Carol Oliver: Great.

Angel Velez: In terms of the juvenile justice and criminal justice populations – access a lot of the service agencies in a state, how are the prevention programming directed towards them?

Carol Oliver: Do any other panelists want to answer that?

Dianne Harnad: I didn't hear the last part of it. How is prevention programming in the criminal justice ...

Angel Velez: Directed towards the juvenile justice and the regular criminal justice population?

Male: Well, the residential student assistance program in New York – it really targets adolescents at risk. The age group is 14 to 17.

So if you do a search for Ellen Morehouse in Google, the information on that program will come up for you. Ellen – and that's Morehouse with one R. And that's where you could start with that. And she would be able to help you enormously.

Angel Velez: Thank you.

Joan Alvarez-Rashid: This is Joan Rashid, also from OASAS. Another program that has been targeted towards juvenile justice offenders in that age range is multi-systemic therapy, MST.

Female: Right. I was going to say that, too.

Female: And who put that program out?

Female: (The postnic) from Florida, I believe.

Female: OK.

Female: Actually, North Carolina.

Female: Oh, in North Carolina now, OK.

Female: But it's been around for about 27, 28 years.

Female: Yes.

Female: So it's a proven program.

Female: Yes, really, I think that program was developed in the context of sort of – in a treatment context that eventually started to be used, I think, across the board. So it's a good one to look at. Dianne, I was wondering if there's any examples from Connecticut about how your criminal justice partners have been involved in your conversations about promotion and prevention.

Dianne Harnad: Well, both Juvenile Justice and the Department of Children and Families – they're all – they're both represented on our statewide policy councils. And they have adopted use of evidence-based and science-based programs. In both of those programs, we did find the residential student assistance program.

We did use that in a DCF residential program, when we had the State Incentive Grant. And it was actually sustained through the Department of Children and Families. And multi-systemic therapy is also a program that the Department of Children and Families uses a lot with Juvenile Justice in their own population. So I think the way that, you know, they've used it in Connecticut is just that they're aware of what the evidence-based programs are, and that they've been adopting them, as dollars become available.

Barbara Gassner: I have a question – Barb Gasner.

Female: Yes?

Barbara Gassner: And right now, a lot of the work that I'm doing is with families on issues of secondhand smoke, and exposure to secondhand smoke for children, infants and youth. So it's wonderful to reduce that exposure. But I'm also really familiar with – from work in the field, as well as from

some research, that there's a higher incidence of depression and anxiety in general among smokers.

And I'm watching those kinds of issues impact parenting. And I'm wondering if anybody's doing any work on, or has developed any programs specifically, dealing with tobacco issues related to parenting and prevention around children, other than the medical issue of exposure to secondhand smoke.

Dianne Harnad: That's very interesting. There's a lot of bright ideas in this country. That's a great idea. I mean, what you're talking about is something I hadn't thought of. And I'm not sure a lot of other people have, either. But that's – that is definitely an area of concern.

Barbara Gassner: Do you have any resources or any suggestions for anywhere to go to pursue the conversation?

Deb McLean-Leow: Barbara, this is Deb.

Barbara Gassner: Hi, Deb.

Deb McLean-Leow: The example that you use around smoking – I think there's been some recent research that I got from Bob Dennison, with the anti-drug campaign that he does – the national ONDCP anti-drug campaign – around marijuana and some similar effects.

And I'm wondering if maybe Bob could be – they're two different substances that you're talking about. But what I'm thinking is perhaps the types of interventions may parallel. So Bob Dennison at the ONDCP could be a resource for you. And we can get you his e-mail address.

Barbara Gassner: That would – that would be great. I can e-mail you later and remind you.

Deb McLean-Leow: Yes.

Barbara Gassner: OK. Thank you.

Male: But what Bob does is data-casting messages over the Internet and over major networks. And that medium works also depending on how accurate the ad is. But I think there's so much out there already about parents who are smoking, and the effects of smoke on the child's health and the parent's health, that I think we may have to go toward some environmental strategies and policy changes that invade people's homes and prevent them – when I see youth in the car with a parent with a window up, and they're smoking, and I say to myself, this shouldn't be. And how do we address issues like that?

So we're looking at environmental strategies at CSAP – SAMHSA for those kinds of things there, where you really can't – you're hoping that if it's the law, it will deter people from doing it. And if there's a penalty, it'll deter. I'm not saying that at this point we're doing it for tobacco. But it could evolve to the issue that you just brought to the table.

Female: That's great.

Barbara Gassner: ... typically what we've been doing here – this is Barb again – what we've been doing here is an in-home visit and parental education.

Female: Yes.

Barbara Gassner: What we're finding is a lot of people want to quit smoking. They're not as tuned into the effects of their smoking on their kids. But when they want to quit smoking, of course, we

bumped into the issues around depression and anxiety. So that's just – give you some framework for what our experience is here.

Female: I think, that's a very typical barrier towards quitting smoking. I mean, it's one of the disincentives is that depression and anxiety that people face once they're off nicotine, so ...

Jon Dunbar-Cooper: Yes. Exactly. Exactly.

Carol Oliver: So we're coming close to the end of our time. Are there any other questions, or even comments that people want, before we begin to wrap up?

Female: Carol, I know I've been asking a lot of questions. But I'm really curious to know if anyone on the phone can share with us, you know, if they've been doing work in this area, you know. How have you been approaching prevention in the context of mental health and substance abuse? I'm sure folks out there have been doing some good work, or starting to think about things that they can do. So I'm curious to hear from the phone audience.

Jon Dunbar-Cooper: I suggest that you contact COCE – that's C-O-C-E. I don't have the Web site. They've done some papers on prevention. But right now, as one of the – as Jim said, the policy academies are really focusing on systemic changes at the state level, integrated services, around co-occurring disorders. And that's a generality that I'm seeing there.

Of course, that's a generality that we're hoping that with that, at least it will start a comprehensive approach to treating people with co-occurring disorders. That said, there are all the windows of opportunity, if you want to speak of them, along the continuum of care. And where do you intervene?

Is it intervention – is it an intervention when you find out that seniors are abusing prescription drugs, and they also have a mental illness – is that prevention if we intervene at that point and give them help, counseling? Are we preventing them from going on with the practice, or is that an intervention, because they're already using? So there are these gray areas.

And I think one of the challenges that SAMHSA has in this is that there are pockets of money there for prevention and treatment of mental health. And each center has its agenda. And Mr. Cuhrie's matrix, the SAMHSA matrix, is forcing us to look across disciplines, and look at what we're doing, so that we are doing research on the best practices, evidence-based practices, for co-occurring disorders.

We're not there yet. We've been looking at the prevention programs we have, the treatment programs that are out there, the mental health programs that are out there; how they can be integrated. And I think that's as far as the federal perspective has gone right now. But definitely, COCE probably has more in-depth stuff that they can ...

Female: Yes, Jon, I was wondering more about from the practitioner perspective locally if they're coming up with any innovative sort of strategies.

Jon Dunbar-Cooper: Well, the Center of Co-Occurring Excellence is there to provide that kind of assistance to you ...

Female: Yes, yes – no, I'm familiar with that. Is there anyone else on the phone, in terms of the phone audience, who can share with us some of what you've been doing locally?

Jon Dunbar-Cooper: You mean pragmatic stuff that works?

Female: Yes, yes. Yes, just from local practitioners on the phone, if there are examples that you have, I'd love to hear from you.

Jon Dunbar-Cooper: Well, it's a new field, and fast evolving. And so, a year from now, I'm sure we would have a lot more to say about your question that you just asked.

Female: Yes. OK. Thank you.

Carol Oliver: Well, I want to thank everybody. I want to thank everybody who participated on the call. And I want to thank the presenters. And this is really the beginning of – and I think the theme that really came out was the window of opportunities.

And I really think that this whole call was a window of opportunity to provide different perspectives on the role of prevention in co-occurring disorders. And I want to thank everybody for being a part of it. And I'm going to turn it over to the operator, who's going to go through some just – procedures for us to do a little bit of evaluation in reference to the call.

Operator: Thank you. As she said, at this time, we would like to conduct a brief electronic survey. After I finish reading the entire question and all of the possible responses, please answer by firmly pressing the star key, followed by the number on your touch-tone phone that corresponds to your choice. Please rate your satisfaction with each of the following aspects of today's workshop.

For our first question: The quality of the information you received – press star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied. And we'll pause for a moment.

For our second question today: The relevance of the information to your work – press star one for very satisfied, star two for somewhat dissatisfied – I'm sorry – for the relevance of the

information to your work – star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied.

For our third question: The organization of the workshop – press star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied. For the next aspect of today's workshop, rate the sensitivity of the trainers to the participants. Press star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied.

Question five is the opportunity for questions and discussion. Press star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied. Question six: Please rate the handouts or materials. Press star one for very dissatisfied, star two for somewhat dissatisfied, star three for somewhat satisfied, star four for very satisfied.

For our final question: How likely are you to use the information or ideas that you received in the workshop? Press star one for not at all likely, star two for not very likely, star three for somewhat likely, star four for very likely. We want to thank you for participating in today's survey, as well as for your participation in the call today. That does conclude today's conference call. Thank you again for your participation, and have a great day.

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